

Medical History Questionnaire

Date: _____

Name: _____ Home/Cell phone: _____

Address: _____ Work Phone: _____

City: _____ Employer: _____

Birth Date: _____ Primary Care Doctor: _____

Referred by? _____ Social Security #: _____

Email address: _____

Eye History

Please check any of the following that pertain to you:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Missing areas | <input type="checkbox"/> Halos/distortion | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Dryness/gritty | <input type="checkbox"/> Redness | <input type="checkbox"/> Itching/burning | <input type="checkbox"/> Styes |
| <input type="checkbox"/> Glare | <input type="checkbox"/> Flashes/floaters | <input type="checkbox"/> Foreign body | <input type="checkbox"/> Excess tearing |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Droopy Lid | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Macular Degeneration | | |

If you checked any of the above, please report when it started, which eye, for how long, does anything make it worse or better, and any information that may help us to help alleviate your symptoms: _____

Do you wear glasses? (Yes or No) If yes, do you want new glasses? (Yes or No)

Do you wear contacts? (Circle) Yes or No

If you are a new patient and wear contacts, what is the brand and power? _____

Would you like to try contacts? (Circle) Yes or No

Medical History

List all medications you currently take (include birth control, aspirin, over the counter, home remedy, and vitamins) or circle NONE if you don't take any meds. If you have a list, we can photocopy it for you: _____

Allergies to medicines: Yes or No. If yes, please specify: _____

Continue on back

Family History

Check and specify who, in your immediate family (mom, dad, sibling, children), has any of the following:

- Cataract _____ Glaucoma _____ Thyroid _____
- Macular Degeneration _____ Hypertension _____
- Cancer _____ Crossed Eyes _____ Lupus _____
- Heart Disease _____ Kidney Disease _____ Diabetes _____
- Arthritis _____ Retinal Detachment _____

Social History

Check any of the following that pertain to you.

- alcohol tobacco illicit drug use

Surgeries:

- Lasik R: _____ L: _____
- Cataract R: _____ L: _____
- Eyelid lift R: _____ L: _____
- Secondary Cataract R: _____ L: _____

Review of Systems

Please check any of the following that pertain to YOU:

- Diabetes I / II Thyroid Allergies Headache
- Weight loss/gain or fever Cancer Heart disease Hypertension
- Stroke Cholesterol GERDS Prostate
- Anemia Osteoporosis Arthritis Joint Replacement
- MS Parkinson's Asthma COPD
- Eczema Rosacea Hearing loss Dry mouth
- Pregnant or nursing (if female)

If you checked any of the above, please specify how long, and if you're under any treatment:

By signing below, you agree the above information is correct.

Patient: _____ Date: _____
